USAF Public Health

PH Shop Talk

Volume 3, Issue 2 Mar– Apr 2002

4N-4F– 4E Merger Briefing Update

This is an article covering what the CFM's brief when we visit bases.

Background: There are two major driving forces for this merger. Many folks don't really understand why we are doing this. Some think the leadership is crazy for taking us down this path. I think a little history of this situation is in order here. Back during the Gulf war (Desert Shield and Desert Storm), the USAF deployed many Squadron Medical Element (SME) packages which consists of a flight surgeon and two Aerospace Medical technicians (now 4F's). In the after action reports post war, the flight surgeons had a major complaint with the technicians who accompanied them. The technician's clinical skills necessary at the deployed locations were somewhat lacking according to the flight surgeon reports. This was due to the technicians having to split their time between clinical training and keeping up with the periodic flying and non-flying physicals (in PES). It was and still is very difficult to keep currency in both a clinical and administrative world. There were two completely different worlds pulling at these technicians. The enlisted leadership at that time implemented an extensive training program to try to improve the clinical skills of the enlisted force. Then came the air war over Serbia. The USAF leadership deployed IDMT's with the flight surgeons to deployed locations. This seemed to solve the problem at the deployed locations. Except that there were many more locations to staff than we had IDMT's with which to fill them. Again, we filled some locations with SME technicians (4F's) and it was at these locations we still had some difficulties with lacking clinical skills. During this period of time the current SG had initiated a review of AFSC's with the goal of reducing the total numbers within the AFMS. It was during this review that the overlap of tasks between the 4F and 4N career fields was identified (an almost 60% overlap). This led to the potential merger of these two fields. The question then became: how do we run the standards section within the MTF? The original plan was to have 4N's and a few 4A's run a medical standards section (keeping the PES section alive). This was started back in the 1996 time frame. As the time to merge came closer, many questions arose causing some concerns. One such question was…with the rotation of 4N's and 4A's…how would the AFMS develop long term expertise (to staff MAJCOMS and special duty locations such as DOD-MERB, AETC etc)? The usual rotation plan for 4N's and 4A's are about every two years or so…which would mean most would only work in the Medical Standards section once in their careers (twice at best)…causing a severe lack of long term expertise (lets face it…it takes a long time to really get good with knowing the standards). Another question concerned the management and financial concerns with training the 4N's to perform audiograms. There are about 1400 pipeline 4N's trained every year…and we only need about 200 people to perform audiograms throughout the entire AF at any given time. It was too expensive to train all 1400 every year. The alternative was to have each MTF decide who was to get trained and to send them back to school for the training. This is more expensive (TDY to school dollars) and again, with the rotation schedule as it was… the AF would be sending many more folks back to USAFSAM for the training… besides making the management at the local level somewhat more difficult.

In Sep 2001, the PCO folks (Col Sean Murphy and staff at AFMOA) met with Col Van Hook (AFMOA PHO) and Col Saenger (AFMOA FS) to discuss some alternatives and solutions to fix and address these concerns. This is when the idea came up that a smaller career field would be best to perform audiograms and that the AFMS needed to retain some expertise in Medical Standards. They tried to address the leadership about retaining the 4F field. This choice was emphatically shot down…it was not on the table for discussion… other alternatives had to be explored. This is when the CFM's from the concerned parties were briefed on a potential redistribution of tasks to the 4E career field. The SG leadership was briefed on the proposal and the CFM's were told to explore this possibility. There was a large group of people (from various career fields) brought to Bolling AFB to discuss this proposal and to determine if Public Health was the right choice to redesign and realign these tasks to. There was consensus on this proposal. The results were briefed to the SG corporate leadership and the proposal was approved. We were approved to set up some test bases and design the processes to make sense and to develop policy and lessons learned for the rest of the AFMS. This has been an on going process and will yield tremendous benefits for all of us. The lessons learned will be distributed late July or early August and the policy should be sent out by late August or early Sep (prior to the merger…what a concept…this is the first time this has happened that I know of since I came in the AF back in the 70's). The classification change request has been approved by AFPC and the change will take effect 1 Nov 02. Make no mistake…it is going to happen…be prepared!

Getting Your Team Together!

The best advice I can give you to be prepared is to form a merger team at your local MTF level. This team should consist of (but again is not limited to) the senior 4N, 4F, 4E, PHO, FS, medical readiness and education and training folks at a minimum. Please keep in mind that this merger effects the entire MDG and not just AMDS communities. Try to imagine that come 1 Nov 02…the PES section as you know it today disappears and about 40% (AF wide) of these 4F folks will no longer be working as EMT's or performing clinical (physical examinations) duties. They will not be available for ambulance response or disaster response as a medical technician. They will be working under the 4E CFETP…and must be considered as all other 4E personnel. In effect, your MTF is reducing its medical technician numbers…the methods your facility uses to respond to in-flight emergencies and disasters must be reviewed and some processes must be redesigned with different people performing these tasks. You can include many other personnel in your MDG as you need them for planning for the merger. Some MTF's include Squadron CC, Supt, OPS officers, and flight leadership. The bottom line…who ever is in your group… ensure the rest of the facility is kept in the loop on what is happening. Communication will be the key to success for the merger. This is why the three CFM's involved with the merger process (Chief Harms – 4N CFM, Chief Cahill – 4F CFM and I) travel around to as many bases as we can to get the information out there and to help MTF's start the planning process. We all want this merger to go as smoothly as possible. The three of us work closely as a team...we encourage the MAJCOMS to have a close working team and for each base to develop this teamwork as well. You all need to start talking about the merger and start planning how to make the transition to the new processes. It takes time and energy to plan...and the policy should be out soon. Stay tuned...but start talking!

4 F Duties...what happens to them?

Division of duties: The 4F duties within the PCM team in flight medicine along with the operational medical duties (jump and range coverage, aircraft accident investigations grounding management, contact lens program, etc) and the medical duties of the SME's will all move to the 4N career field. The paraprofessional portion of the physical examinations section will also be moved to the 4N field (within the PCM teams). Also the patient follow-up that has been traditionally performed by 4E folks (STD, TB, and animal bites) will be transitioned to the PCM teams. However, the initial investigation, education and reporting will still be performed by 4E folks.

The MTF POC for medical standards will be retained in Public Health in a section called Force Health Management. This section will include deployment processing (medical intelligence, pre and post deployment surveillance and medical records screenings), profile management (using the PIMR software), waiver quality control (using AIMWTS software), management and tracking of PIMR database to include occupational health examinations (including performing audiograms), consultation for immunizations (can be either in the Force Health Management or the Community Health Management sections), and the Point of Contact for non-empanelled patients needing physical examinations.

This is not an all inclusive list...just a short list of major categories. The guidance coming out will have the entire list and will explain how the functions will work. Stay tuned...more to come!

Area of Concern: Policy

There are several areas of concern. I will try to highlight these areas…but I cannot cover them all (if I tried…this would be the length of a novel)…

Policy: We desire to get policy out to you NLT the end of Sep 02…we have eight test bases helping us write this policy. They have tested many aspects of it (sometimes several different methods and processes) and will be very helpful to crafting the policy to what will really work at base level. Many times policy is written by folks who have never actually worked the processes at base level. We want tried and true policy to help you with your operations in the field. These bases are in each of the major MAJCOMS and there are several folks from each major area at each MTF who contribute to the policy (not wanting just an AMDS or PCO perspective exclusively). These bases are Andrews (AMC), Altus (AETC), Aviano (USAFE), Buckley (SPACE), Hurlburt (AFSOC), Holloman (ACC), Misawa (PACAF), and Robins (AFMC). We have a very talented team of folks who represent these bases and have worked very hard to get where we need to be on this project. I really appreciate their efforts…I am sure you will too once you see the policy and lessons learned.

Area of Concern: Resistance to change

This is a big area of concern throughout the AFMS. There are many folks who do not like change at all. This merger will upset their apple cart (so to speak). Overall the 4F community has been talking about this merger for years and they want it to be over with. Most are unhappy with the dissolving of their career field…but since it must happen…they will make the most of it.
The 4E community was in shock at first… but once they see how much of the tasks coming our way we are already involved with and see what is being built…most do not have major problems with it…our folks have always been up to the challenge and will tackle this with enthusiasm and dedication. We have great people out there (I have had the pleasure of meeting many of them recently during my travels…and I have been very impressed with the ones I have met). At first the 4N field thought there was not much change coming their way…but as we have peeled the onion back and as the processes are redesigned…the 4N folks (especially the PCO team members)…are finding out that it is a change for them (especially the bases where the PHA has been done in PES) since PES is going away and the PHA processes will mostly be done within the PCM teams. There are more 4N's being pulled into the disaster and in-flight response processes at the local levels. The 4N's are now going to be able to have assignments as SME's (which will become IDMT's by 2005).
Other resistance we have found during our travels include flight surgeons (now that their EMT staff is being cut) and their working relationship with the medical standards technicians is changing (now will have to include the PH folks – senior PH enlisted and PHO in many cases)…and their relationship with the senior 4N in the facility as opposed to the senior 4F (who used to work for them)…
We have found pockets of resistance within the PCO world (at base level)… when they hear that patient follow-up (i.e. STD and TB) and occupational health exams might come their way… but when they see how we are redesigning the processes…most have agreed that it makes sense.

Area of Concern: Health Service Inspections

Another major area of concern to many folks out in the field concerning this merger is how the Health Services Inspections will evaluate a facility. Specifically, will PH be held accountable for things they do not control? This has been a problem for many years. We will attempt to fix this problem with a re-write of the elements of the HSI Checklist. The elements will read something like "were units notified of personnel needing PHA or IMR requirements addressed by medical personnel and were PCM teams notified of PHA or IMR requirements for AD members empanelled to them?" Other elements concerning the rates will be reworded to reflect the reporting of rates to both the medical and line leadership. The overall PIMR rate should not be buried down in the PH elements…but rather a line leadership and medical leadership item. The elements should read something like "were rates less than AF averages appropriately addressed and are there plans in place to improve those rates?" There is a tremendous amount of dialogue and effort being placed into ensuring that the checklists are appropriate and that they measure correctly the behaviors the AFMS is trying to drive. If there is a problem with the way medical personnel are addressing PIMR and Occupational Health Examinations…then the elements should be written to reflect a medical unit problem…but if the problem is within the line units the medical unit should not be written up. There are a couple of base level folks helping the AFIA team with the re-write efforts. AFMOA is also spending time discussing these efforts with AFIA. We will do the best that we can to ensure our folks do not get beat up without good reason.

Area of Concern: Peace/War Ambulance/Disaster Response

Another area that bases need to spend some time with planning is in the area of how the MTF responds to disasters and in-flight emergencies. Some bases have already worked this issue out and have solved their problems while others have not even begun to think about how this merger will effect their response (both peacetime and wartime). Come 1 Nov 02 the 4F's in the Facility Account Code (FAC) 5318 (old PES) will become 4E personnel. This reduces the number of medical technicians who are eligible to respond to disasters, in-flight emergencies and wartime tasked UTCs. Therefore, your leadership must redesign how they respond accordingly. The medical readiness folks should pull out the Operations Plans and the MCRP and UTC list and ensure the right personnel are assigned (now most likely using a larger 4N pool). Remember, the 4N's left in flight medicine are part of a PCM team just like the PCM teams in family practice… they should be treated like one. Make sure that they are not the ones always pulled for MTF response…unless your leadership accepts the problem of shutting down the Operational PCM team every time your unit responds to a contingency. This may cause problems with flyers not being taken care of appropriately (causing some major concern from the Wing Commander). This is just some food for thought.

Area of Concern: Enlisted Promotions

This area has been discussed at length at almost every base the CFM's have visited. There will be a SKT exemption for CY 03. This means that all 4E folks will only take the PFE test (those competing for SSgt – MSgt) and compete only against other 4E's going for the same stripe (and all 4N's will compete against only other 4N's). This is a potential problem if a person scores only a 35 on their PFE (because now it will count for their SKT also…totaling a 70 out of 200 for total test scores). If a person scores well on PFE each year…then they should score well overall. Bottom line: If you are competing for promotion to SSgt through MSgt as a 4E or a 4N after 1 Nov 02…get your hands on the study materials early and study, study, study! Remember, the SKT comes back in CY 04…so study, study, study the new CDC (and test materials listed accordingly) as soon as you can get them…we do not want anyone to be at a disadvantage so get the test materials and study hard. Those competing for SMSgt and CMSgt in CY 02…will compete as their AFSC now…yes we will have a few 4F folks make SMSgt and CMSgt in Nov and March as 4F's even though they are at the time of notification either a 4N or a 4E. The promotion eligibility cut off date (PECD) was prior to the merger effective date so they compete as a 4F.

Area of Concern: Manning and Staffing Issues

It is difficult to cover all of the manning (spaces) and staffing (faces) issues on paper, but I will attempt to cover the basics. Please let me know if you have specific questions concerning manning and staffing. There are a lot of factors that come into play with this issue that it would take a second novel to cover them all.

Spaces: The manning models used for the three areas (FM, Operational Medicine, and FHM) are as follows:

Flight Medicine: Earns one FS (doc), 2- 4N's, and a 4A for the first 750 eligible enrollees. The second 750 enrollees earn a second doc, two more 4N's, and a nurse (this doc and two 4N's are categorized as operational medicine support and considered as part of FAC 5310-1).

SME: All SME positions are to convert to 4N positions. Usually this equates to one doc and two 4N's for each flying squadron. There are some extra SME positions to support other units out there… but this formula is a general rule.

Force Health Management (Old PES): One 4E is earned for every 1,000 active duty (all services…Army, Air Force, Navy, and Coast Guard) assigned.

Authorizations: The above is what is earned not what is funded as your actual positions or authorizations. Your funded authorizations are usually less than what you require. When your facility is planning on dividing the 4F authorizations into the different FAC (5310-FM, 5310-1-Operational Medicine, and 5318-FHM), your team must take the entire 4N, 4F, and 4E mission and manning picture into account. There may be bases where there are very few non-empanelled patients (DODMERB, ROTC, students etc) such as some overseas bases where it might make sense to reduce the numbers within the FHM area (make sure you review all other areas of workload before deciding to reduce those numbers…to make sure the rest of the PH folks can absorb that function). There may be bases where the FHM mission is bigger than the 1 per 1,000 formula thus requiring more personnel to perform the mission. In that case you could look at the operational medicine area to see if there are any slots that can be moved to FHM. These are just a few examples of adjusting manning slots…the bottom line is that good judgment must be used looking at the big picture and not focusing on just one area. Contact your MAJCOM functional representatives if you have any particular questions concerning manpower at your facility.

Faces: Many bases might be forced to make some hard decisions when it comes time to move people into positions. Some folks (4F's) may not get what they want (as their choice of career field). Some that wanted to become a 4N may be forced to become a 4E (and vice versa). The decision is made locally through recommendations from the 3 senior functional reps (4N, 4E, and 4F)…but the final decision rests with the MDG CC. There are some bases that have tried to game the system and move slots around and double book people just so that folks can get what they want. The MAJCOMS and AF CFMS are looking at this very closely and will intervene as necessary to prevent any inappropriate actions. The bottom line is: all missions must be covered and have experienced personnel assigned to complete the mission (and to train others).

Area of Concern: Mission Creep

Another major area of concern is mission creep. There might be a tendency for folks to want to utilize the 4F personnel converting to 4E in a clinical role post merger. This is unacceptable as it causes the new 4E to work outside their scope of practice (not within their CFETP and STS requirements). It also increases the risk of potential lawsuits if a negative outcome results. Besides they have a very large new mission to learn (food safety and security, facility sanitation, medical intelligence etc). Please keep your eye out for mission creep not only in FHM and PH areas…but in the 4N areas as well…the goal is to have clinical work done in the 4N side of the house and the administrative work done in either the 4A or 4E side of the house. Let me know if you have any questions or concerns in any of these areas of concern.

Area of Concern: Training

There will be a tremendous amount of training going on over the next few years in both the 4N and 4E (PHO also) world. This area is a brief summary of the training that is coming up.

3-Level: The 3 level class starting in Sep is the first class with the new material added. Ten days have been added to cover medical standards, profile management, hearing conservation, and other programs that are being added to PH. The new 4N course (no new time added…just new material which replaced other material removed from the course) starts in Nov 02.

PHO basic: Two days have been added to the course to cover management of these new programs. The first class starts this fall.

CDC's: This is a short summary of the CDC training:

1. Current 4E personnel in upgrade to 5 skill level: you will finish your current CDC's and then take a distance learning tool to learn the new material. Personnel entering upgrade training (to 5 skill level) after 1 Nov 02 will be required to complete the new 4E CDC (coming out in Oct 02). There are no transitional CDCs to take for 4E personnel.
2. Current 4F personnel converting to 4E: You will be required to take the 4E CDC's after 1 Nov 02.
3. Current 4N personnel: Must complete the 4N transitional CDC (containing 4F material coming over to 4N field). This course must be completed NLT Jun 03.
4. Current 4F personnel converting to 4N: You must complete the 4N Transitional CDC (containing 4N material that will be your new mission). You also must have this course complete NLT Jun 03.
5. The new 4N CDC will be out sometime after Jan 03 and anyone in upgrade training at that time will be required to take it.

Bridge Courses: There will be bridge courses held at Brooks (USAFSAM) for those Public Health personnel including 4F personnel who convert to 4E.

Current 4F personnel (5 and 7 skill level prior to Jun 03) will attend a 3-week course to learn traditional PH missions. These courses will be held 4 times a year for two years.

Current 4E personnel (7 skill level prior to Jun 03 only) will attend a two week bridge course to learn the new mission (medical standards, profile management etc) and they will be eligible to attend the hearing conservation initial certification course immediately after this bridge course (if they will be performing audiograms).

Current 4E personnel (all grades and skill levels) are eligible to attend the Hearing Conservation Initial Certification and Recertification courses.

Distance Learning: There will be both a web based and CD ROM based distance-learning tool available to train on the new PH mission (medical standards, profile management, etc). Public Health Officers, 4E's, 4N's, 4A's, ARC personnel, nurses, providers etc…can all take this distance-learning tool. It will be made available from USAFSAM this fall.

Management Workshop: There will be a transition management workshop held at USAFSAM on 9-11 July and again 10-12 Sep. The target audience is Public Health Officers, senior 4E leadership, and senior 4F (converting to 4E). There will be approximately a day and a half training on each others missions. Then there will be some generic change management training and topics such as training, manpower, etc to ensure base level personnel know what is going to happen during this merger. There will also be some "lessons learned" taught from the folks that tested this new mission (test base personnel). These lesson topics include overview, marketing, ambulance and disaster response, SME management, deployment processing, waiver management, PIMR, Occupational health exam management, hearing conservation, profiles management, processing clearances, management of non-empanelled patients needing physical examinations and lessons from a squadron commander's perspective. Contact your MAJCOM functional representative for more information and quota concerns. There are only 180 quotas (for both workshops) at this time.

Final Thoughts–

I have attempted to give you a short update on what is happening with the merger of 4F-4N-4E. The classification change request has been approved from the Personnel community. This means the change will take effect starting 1 Nov 02. We are trying to identify what guidance needs updating (such as AFI 48-123 and AFMAN 48-133), what policy needs to be written (both via policy letter and in an AFI), and what lessons learned need to be shared.

We will package these lessons learned and forward them out to each MAJCOM and facility through the PH, FS, 4F, 4N, 4A and Commanders (we hope to flood the market with them). The approach will be to give the Pros and Cons of each of the topics that the test bases dealt with (such as scheduling PHA's)...we most likely will not recommend any particular section to perform this function... rather we will tell what worked well and what worked poorly with each way they tested it. We recommend that you start your planning for the merger...but you may want to wait until the policy and lessons learned become available before actually implementing the changes! Start talking about the upcoming changes. Also start the process of determining which faces will become which AFSC. These might be tough choices for some bases. Ensure each 4F really understands the entire scope of each career field (both 4N and 4E)...and all of the opportunities that each field has to offer. An educated person can sometimes make the choices a little easier. The MAJCOM and AF functional representatives can help answer questions and concerns if necessary. We are all on the same team...working hard to take care of our customers. On with the planning!

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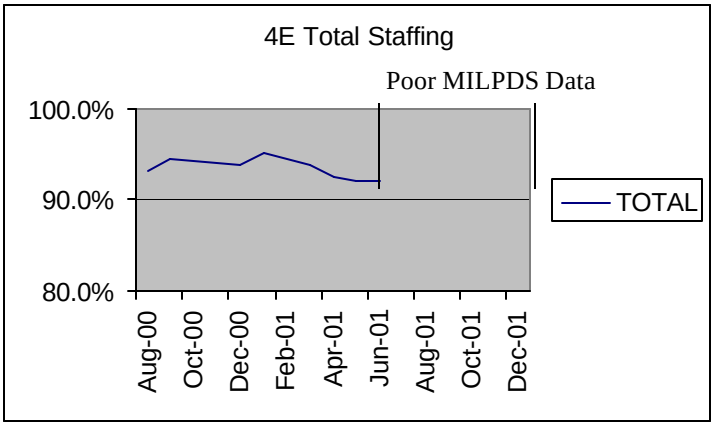

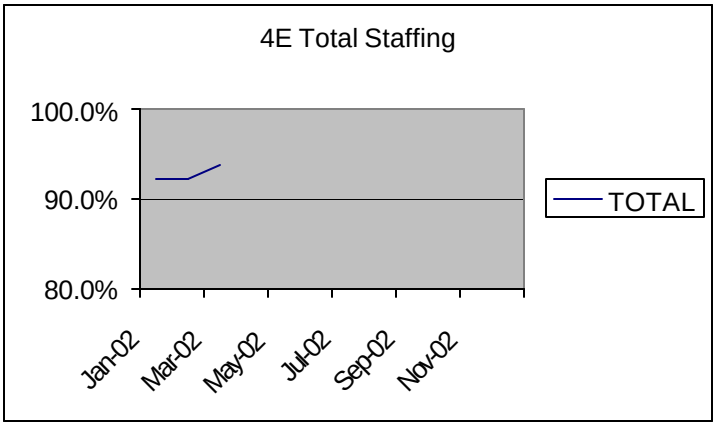

The New Public Health Team

This merger will cause the building of some new teams and professional relationships throughout the AFMS. One such team will be the "new Public Health"...with Force Health Management being a subordinate section. Like individuals, teams progress through different stages of development as they mature. The AF PME curriculum uses the Tuckman model which identifies five stages of team development: Forming, Storming, Norming, Performing, and adjourning (although our team will not adjourn...we will stay around awhile...we might have to revisit the storming stage every now and then as new leadership comes into our offices). Issues and concerns must be resolved in each stage before the group can move on to the next stage. Completion of each stage results in specific task outcomes and specific relationship outcomes that address member needs at that stage. PH leaders should utilize the following information to help them build their new teams. This list provides the basic framework for helping your newly formed team get to the performing stage…(where we want our teams).

Stage One: Forming. Allow time for members to get acquainted; provide essential information about content and process; emphasize new skills required; identify and relate key team values to current task; share stories of past accomplishments and celebrations; create a team vision of outcome; and set goals to achieve that outcome.

Stage Two: Storming. Act assertively and set parameters for the team; listen attentively to all viewpoints; use mediation, negotiation, and arbitration; consider new perspectives and alternatives; and suggest and solicit optional ways to view the problem.

Stage Three: Norming. Provide opportunity for involvement by all; provide opportunity for members to learn from and assist one another; model and encourage supportive behavior; open communication lines; provide positive and corrective task-related feedback; and add some humor and fun to the work setting.

Stage Four: Performing. Reward and recognize performance outcomes and positive work relationships; involve the team in group problem solving and strategizing; share decision-making opportunities; examine how implementation will affect the team and the rest of the organization; and use delegation to foster professional development.

I hope this information helps you transition your new team to an effective and efficient PH Team!